



Hormone Replacement Therapy Paperwork

In order to help determine if you are a good candidate for hormone replacement therapy treatments, please fill in the information below to the best of your ability.

Today's Date: _____

Legal Name : _____ Date of Birth: _____ Age: _____

Preferred Name: _____ Sex: Female Male

Race: White African American Hispanic Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____ Height: _____ Weight: _____

Email: _____

Employer: _____ Occupation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Do you give us permission to contact this person in the event of an emergency? Yes No

How did you hear about our office? _____

Primary Care Physician: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact your doctor with our findings? Yes No

Medical History

Have you ever taken hormone replacement medications? Yes No If yes, when and name the medication? _____

Personal/Family History (check all that apply):

- Deep Vein Thrombosis(DVT)
- Uterine Cancer
- Pulmonary Embolism
- Stroke within last 6 months
- Heart Attack within the last 6 months
- Breast Cancer
- Prostate Cancer
- High Blood Pressure
- Heart Disease
- Blood Clotting Disorder
- Other: _____

Do you have any children? Yes No Are you wanting any children in the future? Yes No

For Women:

Are you currently pregnant/breastfeeding? Yes No Are you taking birth control? Yes No

Do you have a regular menstrual cycle? Yes No

Symptoms

Please check all that apply:

- Depression
- Fatigue
- Body Aches
- Loss of Muscle
- Lack of Sexual Desire
- Muscle Pains
- Unstable Mood
- Hot Flashes
- Vaginal Dryness
- Urinary Incontinence

Medications

Please list all medications you are currently taking including prescription, over-the-counter, botanicals, homeopathic, and supplements:

Allergies

Please list any and all allergies: _____

Consultation for Regenerative and Medical Services

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for care. There will be a one-on-one consultation with the Doctor to:

- ❖ Review my case history to determine if the practice may be able to help me;
- ❖ Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, ect and discuss my problems and answer questions.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended prior to treatment. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____

I have been offered and understand the **Patient Health Information Consent Form**.

I have been offered and agree to the **Missed Appointment Policy** and the **\$50 fee** associated

Patient Signature(X): _____ **Date:** _____